week and for women to limit theirs to below 14 units still looks a good rule of thumb.

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Brief interventions for alcohol misuse

Effective, but not for all alcohol misusers

Despite a plateau in per capita alcohol sales in Britain in the past decade[1] the rise in deaths from cirrhosis of the liver has continued.[2 3] Scottish research also found a rise in discharges from general hospitals for all alcohol related disorders.[3] In part, but only in part, this may reflect doctors' growing readiness to record alcohol problems in medical and surgical patients: in urban hospitals in Britain 15-30% of men and 8-15% of women have alcohol problems.[4] The value of this recognition is that when a doctor or nurse talks to patients about their consumption of alcohol and its pros and cons, providing information non-judgmentally, some patients reduce their drinking and problems from drinking fall.

Control patients in studies showing this effect have been excessive drinkers who received no counselling (other than might have occurred in routine medical practice). Controlled studies of brief interventions in over 4000 patients in medical settings have now been published. Some have presented data not only on self reported consumption but also on objective markers of outcome, such as a fall in serum γ glutamyltransferase activity over the ensuing year[5] or a fall in recorded days of sickness and admissions to hospitals.[6 7]

The most recent issue of *Effective Health Care* has examined randomised studies that used assessors who were meant to be blind to the treatment group and that included measures of self reported consumption of alcohol. Data from the six studies meeting these criteria were pooled: overall, the effect of brief intervention was estimated to be a 24% fall in alcohol consumption (95% confidence interval 18% to 31%).[8] In a meta-analysis published earlier this year of 19 brief intervention studies in non-medical settings, using data with slightly varying measures of alcohol consumption, the mean treatment effect was 38% (range -3% to 64%; SD 33%).[9]

The estimated direct cost of detection and brief intervention in an alcohol misuser to reduce alcohol consumption by an average of one quarter is £20.[7] Decision makers in the health service may be impressed and may question the need for more costly services for problem drinkers.

The decision makers should, however, note two points. Firstly, most of the studies included in these reviews of brief intervention excluded severely affected drinkers who were thought to need psychiatric referral, had symptoms of physical dependence, or who lacked social support. Secondly, although brief intervention may increase the proportion of alcohol misusers who get through a year without drinking dangerous amounts or without problems, large numbers of misusers continue to drink as much or more and develop problems. They need other treatments.

The authors of the study in *Effective Health Care* rightly conclude that for more severely affected drinkers there is no certainty about what constitutes the most effective treatment. The advantages of inpatient versus outpatient care, other than perhaps for detoxifying socially unsupported patients and for those at risks of delirium or fits, have been difficult to show.[10]

The value of brief intervention in less severely affected misusers seems not in doubt. Although severely affected drinkers have the highest rates of alcohol problems, less severely affected misusers are more numerous and contribute more to alcohol's health and social costs. The main ingredients in the opportunistic counselling of such patients have been dubbed FRAMES[9]: Feedback to the patient about personal risk or impairment; emphasis on personal Responsibility for change; Advice; a Menu of alternative options for change; and interviewing which is Empathic and enhances Self efficacy. Health workers should recognise that patients will be at different stages in their thinking about alcohol. Some are already thinking of change. Others are not and resist advice: opening the dialogue may be all that is appropriate then.[11]

Effective Health Care advises on ways of identifying alcohol misusers. Screening instruments have been devised (for example, the alcohol use disorders identification test (AUDIT)[12]), but incorporating into routine medical practice a question on the quantity and frequency of units consumed and whether drinking has led to any problems detects many cases of alcohol misuse, and the question can be repeated later if there is an unexplained rise in γ glutamyltransferase activity or mean red cell volume.

Purchasers should note that the awareness among doctors and nurses of alcohol misuse still needs to be increased. They will also find that, in general hospitals and primary care, nurses who are good at helping patients change their behaviour can be productively employed.

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